HIV ANTIBODY TEST

CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES

LOCAL LABORATORY NUMBER

Unique Office of AIDS Client Number 999-9999-9

SPECIMEN DATE: *(mm/dd/yy)*

RETURN APPOINTMENT DATE: *(mm/dd/yy)*

GENDER: (1) MALE (2) FEMALE (3) M-F (4) F-M

DATE OF BIRTH: *(mm/dd/yyyy)*

RESIDENCE COUNTY: _____

RESIDENCE ZIP CODE:

CONFIDENTIAL TESTING USE ONLY

LAST NAME: _____

SSN: *(last 4 digits, 0000 if unknown)*

SOUNDEX CODE:

RAPID TEST USE ONLY

LOT NUMBER:

EXPIRATION DATE:*(mm/yy)* **COUNSELOR/ TECH INITIALS:**

SPECIMEN: (1) ORAL (2) FINGER STICK (3) VENIPUNCTURE

BEGIN TEST		END TEST	
TIME	TEMPERATURE	TIME	TEMPERATURE
AM / PM	°F	AM / PM	°F

RESULT: (1) PRELIMINARY POSITIVE *(indicate confirmatory specimen)*
(2) NEGATIVE
(3) INVALID, reason: _____

CONFIRMATORY SPECIMEN GIVEN: (1) YES (2) NO

LAB SPECIMEN

SPECIMEN: (1) ORAL (2) FINGER STICK (3) VENIPUNCTURE

LABORATORY NAME & ADDRESS:

_____

_____

_____

_____

CLINIC/SITE NAME, ADDRESS, & PHONE:

_____

_____

_____

_____

LABORATORY USE ONLY

ELISA: (1) REACTIVE (2) NON-REACTIVE

SUPPLEMENTAL TEST PERFORMED:

(1) **IFA**
- (1) REACTIVE
- (2) NON-REACTIVE
- (3) NONSPECIFIC/ UNSATISFACTORY

(1) **WESTERN BLOT**
- (1) REACTIVE
- (2) NON-REACTIVE
- (3) INDETERMINATE

SUMMARY INTERPRETATION:
- (1) HIV ANTIBODY DETECTED
- (2) NO HIV ANTIBODY DETECTED
- (3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN
- SEE ENCLOSED NOTE

NOTE: _____

_____

_____

DATE RECEIVED BY LAB: *(mm/dd/yy)* _____

DATE REPORTED: *(mm/dd/yy)* _____

LABORATORY COPY

DHS 8257 (9/03)

ATTACH LABEL TO REPORT FORM AND BLOOD SPECIMEN

999-9999-9

999-9999-9

999-9999-9

999-9999-9

999-9999-9

999-9999-9

999-9999-9

999-9999-9

SEND REMAINING LABELS WITH COPIES 1, 2, & 3 OF FORM TO THE LABORATORY